



## **Clinical Research Demographic Form**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

**Address:** \_\_\_\_\_  
Street City State Zip

**Sex:** ☐ Male ☐ Female

**Primary Telephone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Type:** \_\_\_\_\_ ☐ OK to text

**Secondary Telephone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Type:** \_\_\_\_\_ ☐ OK to text

**E-mail Address:** \_\_\_\_\_ ☐ OK to send e-mails

**Preferred Contact Method:** ☐ Phone call ☐ Text Message ☐ E-mail

**Ethnicity:** ☐ Hispanic or Latino(a), or of Spanish Origin  
☐ Not Hispanic or Latino(a) or of Spanish Origin  
☐ Prefer not to answer

**Race (Mark all the apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Asian                     | <input type="checkbox"/> White                            |
| <input type="checkbox"/> Native Hawaiian           | <input type="checkbox"/> Other Pacific Islander           |
| <input type="checkbox"/> Prefer not to answer      | <input type="checkbox"/> Other                            |

**Would you like to be considered for future clinical research studies?** ☐ YES ☐ NO

Select Any of Interest:

☐ Blood Test Studies ☐ Data Collection/Surveys ☐ Vaccine Studies ☐ Medication Studies

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



103 East 23<sup>rd</sup> Street, Panama City, FL 32405 | Phone: 850-250-0194 | Fax: 850-250-0194

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, hereby authorize Emerald Coast OB/GYN to use and/or disclose the following protected health information:

Records requested from (Facility/Phone/Fax): \_\_\_\_\_

Records requested to be sent to (Facility/Phone/Fax): \_\_\_\_\_

For the purpose of (circle one): (1) Continuance of care      (2) Insurance      (3) Legal      (4) Self  
(5) Clinical Research Study

#### Information to be Released:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Office Notes      | <input type="checkbox"/> Obstetrical Records | <input type="checkbox"/> Mammography Images on a disc and paper report |
| <input type="checkbox"/> Lab Results       | <input type="checkbox"/> Operative Reports   | <input type="checkbox"/> Breast Imaging                                |
| <input type="checkbox"/> Radiology Results | <input type="checkbox"/> Cytology            | <input type="checkbox"/> Other: _____                                  |
| <input type="checkbox"/> Pathology Results | <input type="checkbox"/> Entire Record       |  |

This authorization shall be valid for three years from the date signed, at which time this authorization to use or disclose protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the Facility address. I understand that a revocation is not effective to the extent that the facility has taken action in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The Facility will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or State Law if it provides greater access rights).
- Refuse to sign this authorization.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital war, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum; HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

\*\*\*\*\* PLEASE INITIAL BELOW FOR LABS\*\*\*\*\*

PLEASE

INITIAL \_\_\_\_\_ Yes \_\_\_\_\_ No

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

PLEASE

INITIAL \_\_\_\_\_ Yes \_\_\_\_\_ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Patient's Social Security Number

Received by: \_\_\_\_\_

# Request for Taxpayer Identification Number and Certification

► Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Give Form to the  
requester. Do not  
send to the IRS.

Print or type.  
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
2 Business name/disregarded entity name, if different from above	
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.  <input type="checkbox"/> Individual/sole proprietor or single-member LLC  <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ <b>Note:</b> Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is <b>not</b> disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.  <input type="checkbox"/> Other (see instructions) ► _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):  Exempt payee code (if any) _____  Exemption from FATCA reporting code (if any) _____  <small>(Applies to accounts maintained outside the U.S.)</small>
5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
6 City, state, and ZIP code	
7 List account number(s) here (optional)	

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number											
				-				-			
or											
Employer identification number											
					-						

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ►	Date ►
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## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)  
Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.  
*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.*